Warsaw, 16th October 2017

***Mr. Zeid Ra’ad Al Hussein, the United Nations High Commissioner for Human Rights***

*Dear Mr. Commissioner,*

The *Ordo Iuris* Institute for Legal Culture welcomes the opportunity to assist the United Nations High Commissioner for Human Rights in its preparations of report on Sustainable Development Goals and Health, mandated under GA resolution 35/23 entitled “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health in the implementation of the 2030 Agenda for Sustainable Development”.

The *Ordo Iuris* Institute for Legal Culture is an independent legal organization incorporated as a foundation in Poland. It gathers academics and legal practitioners aimed at the promotion of a legal culture based on the respect for human dignity and rights. *The Ordo Iuris* has ECOSOC special consultative status. Moreover, it is among organizations consulted by the Polish Government within the legislative process. Polish courts, including Supreme Court of the Republic of Poland, have been accepting our 'third parties interventions'. The *Ordo Iuris* has also intervened before the European Committee of Social Rights and the European Court of Human Rights as well as Constitutional Tribunals of numerous countries including Romania, Croatia, Brazil, Chile. We hope the Commissioner will find our intervention supportive.

*Yours sincerely*,

Prof. Aleksander Stępkowski Dr Joanna Banasiuk

President of the Board Vice-President of the Board

*Ordo Iuris* Institute for Legal Culture *Ordo Iuris* Institute for Legal Culture

The following remarks will apply to **Target 5.6**: Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences **in connection with** **Target 3.1**: By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births.

1. According to ICPD 8.25, in no case should abortion be promoted as a method of family planning and every attempt should be made to eliminate the need for abortion. In this sense, the Cairo document does not treat a safe abortion as a matter of law, but only as a condition for under which abortion can be tolerated. Moreover, any measures or changes related to abortion within the health system can only be determined at the national or local level according to the national legislative process (ICPD 8.25).
2. In this context, the attention should be drawn to the need to ensure women's freedom from coercion of economic and social pressure when deciding on the number of children. Cause for significant concern is the fact that in most cases women have abortions under the influence of economic and social pressures that exist in connection with the presence of stigmatizing stereotypes in relation to motherhood. Therefore, abortion for social reason is often in fact abortion forced by the economic coercion and as such should be considered as a kind of gender based violence against woman.
3. According to CRC (1990), Art. 27-2, parents are responsible for the child and have the primary responsibility to secure the conditions of living necessary for the child’s development. Moreover, as stated in ICPD (1994), II, Principle 10, the best interests of the child shall be the guiding principle of those responsible for his or her education and guidance; that responsibility lies in the first place with the parents. Also according the UDHR, Art. 26-3, parents have a prior right to choose the kind of education that shall be given to their children. Therefore an universal accesss to sexual and reproductive health and reproductive rights as well as information and sexual education for minors requires a prior parental consent (see General Comment No. 4 issued by the UN Committee on the Rights of the Child). It remains in accordance with CRC (1990), Art. 29-1 (c) which states that education of the child shall be directed to the development of respect for the child’s parents (see also ICCPR, Art. 18-4).
4. As stated in Art. 18 of Universal Declaration of Human Rights and Art. 18 of ICCPR, everyone shall have the right to freedom of conscience. Therefore the right of conscience is deeply rooted in international law and the above mentioned fundamental legal guarantees should be respected while achieving an universal access to sexual and reproductive health and reproductive rights also as regard to the health-service providers.
5. The everyone’s right to enjoy the highest attainable standard of health and continuum of care as well as a life-course approach should refer to every child without discrimination of any kind, including discrimination because of the stage of its development or the circumstances of delivery. This is mandatory under the UN Declaration of the Rights of Children as confirmed by the UN Convention of the Rights of the Child to ensure the special safeguards and care, including appropriate legal protection, before as well as after birth. There is an urgent need to protect the rights of children to life and to human and respectful treatment, including those born alive as the result of a late-term abortion.
6. It is therefore useful to focus on the grounds of positive changes in reduction in maternal mortality rates achieved since 1990 to 2015 according to the Worth Health Organization (WHO).[[1]](#footnote-1) Analysis of official data shows that wider access to abortion in countries such as the United States, United Kingdom or France is correlated with a higher level of maternal mortality than in countries where the law provides a better protection of human life in the prenatal phase of development. It is contrary to a groundless thesis stating that wider access to abortion would ensure a higher level of maternity care. No such evidence exists that will prove that abortion or more widely access to abortion make pregnancy and childbirth safer for mothers and result in a reduction in the rate of maternal mortality. Contrary to this, the landmark study from Chile clarified the measures that reduce effectively maternal mortality. During a 50‐year period from 1957‐2007, that country’s maternal mortality rate decreased 93.8% to one of the lowest in the world.[[2]](#footnote-2) It is worth mentioning, that since the introduction of the law completely banning abortion - within 14 years since abortion was banned in Chile in 1989, maternal mortality rate decreased by 69,2%.[[3]](#footnote-3) In Mexico, the states protecting human life also before delivery have average maternal mortality ratio 23% lower than the rest of Mexican states[[4]](#footnote-4). In the United States in 1990 maternal mortality rate was lower (1990 – 12/100.000) than it is today (2015 – 14/100.000)[[5]](#footnote-5). The increase of maternal mortality in the US coincides with the liberalization of abortion law. Such a correlation is also visible in Europe. In Poland, after serious reduction of abortion in 1993, the maternal mortality ratio decreased from 15 in 1993 to 3 in 2015[[6]](#footnote-6). Research carried out by the University of Washington shows that Poland is among the countries with the lowest maternal mortality rates in the world and one of few that managed to achieve the 2015 Millennium Development Goals[[7]](#footnote-7). In Western European countries, like Germany or France, where law is much more liberal in 2015 maternal mortality rate was appropriately 6/100.000 for Germany[[8]](#footnote-8) and 8/100.000 for France[[9]](#footnote-9). The data provided by the World Health Organization indicates that in 1968 (before the legalization of abortion) maternal mortality ratio in England and Wales was significantly lower than in the Republic of Ireland. Since the legalization of abortion in England and Wales the maternal mortality raised and has been significantly higher than in Ireland, which guarantees the high level of protection of life[[10]](#footnote-10). The above-mentioned data clearly shows a positive correlation between the intensity of protection of human life in the prenatal stage and the protection of the maternal health.
1. *See* Trends in maternal mortality: 1990 to 2015 Estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division, World Health Organization 2015, <http://apps.who.int/iris/bitstream/10665/194254/1/9789241565141_eng.pdf>, [last accessed: 16 October2017]. [↑](#footnote-ref-1)
2. Koch E, Thorp J, Bravo M, Gatica S, Romero CX, et al., "Women's Education Level, Maternal Health Facilities, Abortion Legislation and Maternal Deaths: A Natural Experiment in Chile from 1957 to 2007," (May 2012) PLoS ONE 7(5): e36613, [http://www.plosone.org/article/info%3Adoi%2F10.1371%2Fjournal.pone.0036613](http://www.plosone.org/article/info%25253Adoi%25252F10.1371%25252Fjournal.pone.0036613), [last accessed: 16 October2017]. [↑](#footnote-ref-2)
3. Maternal mortality ratio in Chile: WHO, UNICEF, UNFPA, World Bank Group, and the United Nations Population Division. Trends in Maternal Mortality: 1990 to 2015. Geneva, World Health Organization, 2015, <http://data.worldbank.org/indicator/SH.STA.MMRT?locations=CL&name_desc=false>, [last accessed: 16 October2017]. [↑](#footnote-ref-3)
4. Koch E., Chireau M., Pliego F., Stanford J., Haddad S., Calhoun B., Aracena P., Bravo M., Gatica S., Thorp J., *Abortion legislation, Maternal healthcare, fertility, female literacy, sanitation, violence against women and maternal deaths: a natural experiment in 32 Mexican states,* [in:] „BMJ Open”, p. 8, [http://bmjopen.bmj.com/content/5/2/e006013.full.pdf+html](http://bmjopen.bmj.com/content/5/2/e006013.full.pdf%2Bhtml), [last accessed: 16 October2017]. [↑](#footnote-ref-4)
5. Maternal mortality in 1990-2015: United States of America, WHO, UNICEF, UNFPA, World Bank Group, and United Nations Population Division Maternal Mortality Estimation Inter-Agency Group, <http://www.who.int/gho/maternal_health/countries/usa.pdf>, [last accessed: 16 October2017]. [↑](#footnote-ref-5)
6. Maternal mortality ratio in Poland: WHO, UNICEF, UNFPA, World Bank Group, and the United Nations Population Division. Trends in Maternal Mortality: 1990 to 2015. Geneva, World Health Organization, 2015, <http://data.worldbank.org/indicator/SH.STA.MMRT?end=2015&locations=PL&start=1990&view=chart>, [last accessed: 16 October2017]. [↑](#footnote-ref-6)
7. *See* N. J. Kassebaum et al., *Global, regional, and national levels and causes of maternal mortality during 1990–2013: a systematic analysis for the Global Burden of Disease Study 2013*, [in:] „The Lancet” - vol. 384 September 13, 2014, p. 998, [http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(14)60696-6.pdf](http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736%2814%2960696-6.pdf), [last accessed: 16 October2017]. [↑](#footnote-ref-7)
8. Maternal mortality in 1990-2015: Germany, WHO, UNICEF, UNFPA, World Bank Group, and United Nations Population Division Maternal Mortality Estimation Inter-Agency Group, <http://www.who.int/gho/maternal_health/countries/deu.pdf>, [last accessed: 16 October2017]. [↑](#footnote-ref-8)
9. Maternal mortality in 1990-2015: France, WHO, UNICEF, UNFPA, World Bank Group, and United Nations Population Division Maternal Mortality Estimation Inter-Agency Group, <http://www.who.int/gho/maternal_health/countries/fra.pdf>, [last accessed: 16 October2017]. [↑](#footnote-ref-9)
10. B.C. Calhoun, J.M. Thorp, P.S. Carroll, *Maternal and Neonatal Health and Abortion: 40-Year Trends in Great Britain and Ireland* (data for 2003-2013) <http://www.jpands.org/vol18no2/calhoun.pdf>, [last accessed: 16 October2017]. [↑](#footnote-ref-10)